Report of the Independent Inquiry into the Treatment and Care of **James Ross Stemp**

A report commissioned by

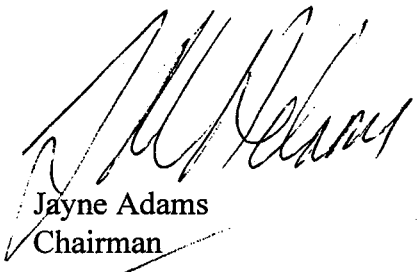
Leicestershire Health Authority

November 1997

PREFACE

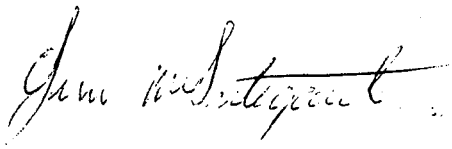
We were jointly commissioned in September 1996 by Leicestershire Health Authority to undertake this Inquiry.

We now present our report, having followed the Terms of Reference which were specified to us and the Procedure which was subsequently adopted and issued to all witnesses and their representatives.



Jayne Adams
Chairman

Philip Douglas
Social Services Advisor



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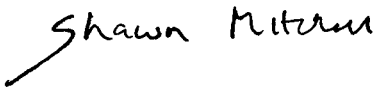
Nurse Advisor



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ACKNOWLEDGEMENTS

Our grateful thanks are due to all of the following:-

Officers of the Leicestershire Health Authority for their willing and contributive help throughout, with particular reference to John McFadyen, Melanie Sursham and Michele Morton.

Staff of Margaret Wort & Co for their friendly and highly efficient transcription services.

All of the witnesses of fact (and especially Mr & Mrs J D Stemp) for their frankness and willingness to co-operate in a process which was personally demanding and at times stressful.

CONTENTS

REPORT OF THE INQUIRY INTO THE TREATMENT AND CARE OF JAMES ROSS STEMP

1. The Offence

1.1 At Nottingham Crown Court on the twenty-ninth day of July 1996 James Ross Stemp was tried and sentenced to life imprisonment for the murder of Mr John Joseph Dawson. James Stemp had, prior to his conviction, entered a plea of Not Guilty and, whilst admitting kidnapping Mr Dawson and tying him to a tree at John Lees Wood, Markfield, Leicester, denied the murder.

1.2 The Consultant Forensic Psychiatrist who assessed James Stemp whilst he was on remand at Her Majesty's Young Offenders Institute Glen Parva, prior to the hearing of the case, noted that:

"Careful examination did not reveal any evidence for delusions, "false beliefs", hallucinations or any other signs or symptoms of major mental illness. Mr Stemp was neither abnormally elated nor depressed at the time of my examinations, although he was curiously detached and seemed somewhat unconcerned about the serious nature of the charges he was facing. Nevertheless, I am of the opinion that he was not suffering from any formal mental disorder."

1.3 At trial no defence to the charge of murder on the grounds of diminished responsibility was put forward on behalf of James Stemp.

2. Personal History

2.1 James Stemp was born in Leicester on the 29 January 1978 with the birth name of Sykes. James' natural parents separated when he was approximately 12 months old and he remained living with his mother.

2.2 James Stemp has a half sister born on the 8 June 1980 who is diagnosed as having cerebral palsy. Both Mrs Stemp and James Stemp described his relationship with his sister as a relatively good one with James Stemp understanding the reasons why his sister needed special attention.

2.3 In October 1984 Mrs Stemp married her present husband, John Stemp ("Mr Stemp"). James Stemp did not regard his step-father positively before the marriage but this relationship improved with time to the point where Mrs Stemp formed the opinion that James' relationship with his step-father was better than his relationship with her. As a result of that marriage a half-brother was born on the 18 April 1986.

2.4 Until the birth of his half-brother James Stemp had an uneventful childhood and a steady school record. At approximately the time when his half-brother was born, James Stemp, who his mother reported to have had a tendency to lie, also started some minor stealing.

2.5 In May 1992 James Stemp was seen by an Educational Psychologist, Ms Julie Robertson. Although Mr and Mrs Stemp did not recall being instrumental in this referral, Ms Robertson recollected that this was at the request of the School Head following concern expressed by Mr and Mrs Stemp regarding James Stemp not performing academically as expected. The information provided to Ms Robertson at the time by James Stemp's teachers, was that he tended to behave in a silly fashion in the class setting but was more mature on a one to one basis. One episode was reported of James Stemp stealing pornographic material from a shop where he was working at the time. He was made to return the material to the shop by his parents. Ms Robertson did not have specific concerns regarding James Stemp and felt that his parents' approach to incidents of untoward behaviour was appropriate. After his move to senior school, teachers reported that they were satisfied with James' academic performance and Ms Robertson therefore closed her file in February 1993. Certainly up until that time Mr and Mrs Stemp did not consider that the behaviour of James was anything other than that of a normal teenager.

2.6 From 1993 there were episodes of James Stemp staying away from home over night, sometimes with friends and, at other times, at places where he had visited with the Venture Scouts, of which he had been an active member from the age of 11. James Stemp attended local schools, completing his education at Longslade Community College where he obtained 6 GCSEs. In September 1994 he returned to re-sit some of his GCSEs and to commence A-levels but he only stayed for a few weeks before leaving to try and find employment. He then embarked on a YTS scheme in engineering and later computing but completed neither of these due to lack of interest.

2.7 On a date recalled by Mrs Stemp as the 8 October 1994, James Stemp had a disagreement with his parents when he borrowed his brother's torch and failed to bring it home. He was then sent by his step-father to find it and in doing so went to the home of friends, the Coley family. Mrs Coley formed the view that it was inappropriate for James Stemp to be out on his own at approximately 9.00 p.m. in the evening and suggested he stayed at their house. In the event James Stemp continued staying with the Coley family for a period of approximately 2 weeks. During this time a meeting was arranged between Mr and Mrs Stemp and Mr and Mrs Coley but little benefit seemed to come from this. James Stemp returned home for a short period of time but then stayed at a friend's flat in Beaumont Leys and thereafter obtained lodgings.

It was reported that James Stemp spent a relatively uneventful Christmas 1994 with his parents. In January 1995 however James Stemp was asked to leave his lodgings by his landlady as she described him, inappropriately in James Stemp's view, as "an irresponsible tenant". Later he said that he discovered she had wanted to utilise the flat for her boyfriend. After James Stemp left his lodgings he stayed in various locations with friends in between sleeping rough.

2.8 The last contact James Stemp had with his parents was at his aunt's birthday party on the 23 January 1995 which took place at his grandparents' house. Although James Stemp described to various professionals, with whom he came into contact thereafter, further meetings with his parents and, in particular, an aggressive episode on the 18 February 1995, this was not true. James Stemp candidly told the members of the Inquiry that he had made up the story to assist in obtaining medical help. Independently of his evidence, Mr and Mrs Stemp also confirmed that they had not seen James Stemp on or around the 18 February 1995 or had any such aggressive dealings with him.

2.9 Mr and Mrs Stemp were informed that James Stemp was on remand at HM Young Offenders Institution Glen Parva in July 1995 but did not visit him there. Although James Stemp attended at Mr Stemp's place of work to leave him a birthday card no further contact was made until after James Stemp had been arrested for the murder of Mr John Joseph Dawson.

2.10 Once James Stemp had been arrested for the murder, Mr and Mrs Stemp, whilst distressed and shocked at the event, have been and continue to be supportive of James. Regular visiting now takes place.

3. Prior Criminal History

3.1 In November 1992 James Stemp was cautioned for carrying a loaded air weapon in a public place. He had removed this without his step-father's permission from his home address and had, with a friend, allegedly fired pellets in the direction of a woman. Whilst James Stemp believed that it was his mother who had reported him to the Police for this offence, Mrs Stemp denied that was so.

3.2 On the 1 February 1995 James Stemp stole some personal effects from the home of someone known to him. He was arrested on the 6 February 1995 and charged with burglary. Whilst in custody he also admitted to the theft of a lamp from a scout hut in January 1995 and was bailed to appear before the Leicester Youth Court on the 7 March 1995.

3.3 On the 13 April 1995 James Stemp was arrested for failing to appear at the Youth Court but released on bail. On the 15 June he was again arrested for failing to appear in Court and on the 16 June 1995 released on bail on the condition that he reside at Howard's House, a Bail Hostel. On the 17 July 1995 James Stemp was arrested for failing to reside in the Bail Hostel and for a further offence of burglary, as a result of which and as previously referred to he was remanded into custody at HM Young Offenders Institution Glen Parva. James Stemp remained in custody until the 1 August 1995 when he was sentenced to 80 hours Community Service and made the subject of a Combination Order consisting of 12 months' probation.

3.4 After being placed on probation James Stemp co-operated fully with his Probation Officer, Ms Shirley Johnson, who gave evidence to the Inquiry and described James Stemp as a most satisfactory probationer in general.

3.5 Ms Johnson considered she had developed a reasonable relationship with James Stemp, with which he concurred. Both Ms Johnson and the Chief Probation Officer found nothing in the Community Service records to suggest that there was any cause for concern about a potential risk from James Stemp. No violence was threatened nor used in the offence for which James Stemp was placed on supervision and "there was no indication at the time of sentence or during subsequent supervision that he was potentially violent."

3.6 In a Risk Assessment prepared on the 27 September 1995 the Chief Probation Officer concluded that "on the basis of available information in relation to behaviour, attitudes, beliefs, values and environmental factors, James Stemp was assessed as low for both likelihood and seriousness."

3.7 The offence of murder committed by James Stemp came as a complete surprise to Ms Johnson and was an offence which, even with the benefit of hindsight, she felt quite unable to foresee.

4. Social Services Contact Prior to the 19 February 1995

4.1 The Stemp family had no contact whatsoever with Social Services until the 10 May 1994 when Mrs Stemp reported that James Stemp had run away from home. Indeed Mrs Stemp had made this report to Social Services upon the advice of the Police. There were no obvious precipitating factors to this event, although James Stemp had run away from home on one or two previous occasions. James Stemp continued to attend school and was reported to be living with friends. As he was over the age of 16 Mr and Mrs Stemp were advised that there was little further they could do.

4.2 On the 12 May 1994 contact was made by Social Services with Mr and Mrs Coley with whom James was then staying. On the 11 July 1994 Mrs Coley confirmed with Social Services that James Stemp had returned home to his parents and remained living there.

4.3 On the 11 October 1994 Mrs Stemp made a second referral to the Social Services Department City West Access Team because James had been missing again.

5. Psychiatric History and Treatment

5.1 James Stemp had received no psychiatric treatment nor indulged in any behaviour that might have brought him to the attention of the Psychiatric Services prior to February 1995. It is the limited period of February and March 1995 upon which the Inquiry has focused its attention.

5.2 The only indication of any difficulty prior to that time was in relation to the referral to the Educational Psychologist.

6. Events of February and March 1995

6.1 James Stemp first came to the attention of the Leicester Royal Infirmary on the 10 February 1995 when he reported having suffered a head injury during an assault earlier that day. He was admitted for observation overnight and discharged the next day only to return in the early evening complaining of dizziness and headache. He was discharged again on the 12 February 1995. James Stemp's time in the Infirmary during this period would seem to have been uneventful.

6.2 James Stemp then went to Coventry where, on the 13 February 1995, he attended at Walsgrave Hospital continuing to report symptoms related to the alleged assault. He was admitted for observations again and discharged on the 16 February 1995. During his admission to Walsgrave Hospital James Stemp was put on 4 hourly neurological observations and a CT head scan was carried out which was reported to be normal. On his discharge on the 16 February 1995 he was provided with strong analgesics for persistent frontal headaches.

6.3 James Stemp returned to Walsgrave Hospital on the 19 February 1995 giving a history of having taken 10 co-proximol tablets on the evening of the 18 February. He was sent to the Accident & Emergency Department at Walsgrave Hospital where no significant paracetamol and salicylate levels were detected on testing.

6.4 James Stemp was then referred to Dr C Dumughn, the Duty Psychiatric Senior House Officer, for further psychiatric assessment. Dr Dumughn took a full history from James Stemp which included recording that he had met with his mother and step-father the previous evening who had taken him to a friend of theirs in Coventry. It was recorded that his parents had been drinking and James Stemp had not, although he thought that his parents were putting gin in his lemonade. He reported that he felt paranoid, told his parents that they were sick and left. James Stemp then reported to Dr Dumughn that he put his fist through the driver's window of his step-father's car because he was so angry with them. Whereupon his step-father came out and James Stemp hit his step-father causing him to have a bloody nose. Dr Dumughn further recorded that James Stemp had a knife with him with which he threatened his step-father and felt close to harming him.

6.5 Dr Dumughn recorded that James Stemp had never felt suicidal before but when he took the co-proximol had wanted to kill himself. He then realised that this was silly. Her impression was that the story provided by James Stemp was an odd one but he appeared labile in mood with some psychotic symptoms. She decided, appropriately, that he needed observation on the ward to form a diagnosis and arranged for him to be admitted to Carlton Hayes Hospital in Leicester under Dr A Whitehouse.

6.6 In her evidence to the Inquiry Dr Dumughn indicated that she considered both the possibility that James Stemp was suffering from a drug-induced psychosis or that he, in common with many homeless young men, merely wanted a bed for the night but generally did not consider that to be the case.

6.7 Upon arrival at Carlton Hayes Hospital in Leicester, James Stemp was admitted by Staff Nurse Mrs B Kramer and assessed by the Duty Doctor, Dr F Nielsen. Dr Nielsen had the advantage of a discussion by telephone with Dr Dumughn and was provided with a copy of the notes made by her at Walsgrave Hospital.

6.8 The notes made by Dr Nielsen, like those of Dr Dumughn, were comprehensive and noted James Stemp to be very agitated, angry and potentially hostile with wandering thoughts and constant speech which was rambling in nature. Dr Nielsen recorded the same history of James Stemp having sustained a head injury when he was assaulted by a drunk man, and recorded also the history of a violent disagreement with his parents in Coventry. Dr Nielsen recorded that James Stemp "believes his parents were trying to muck him up" and that he had brandished a knife at his step-father. James was recorded as saying that he felt "like sticking a knife into his dad". He heard his thoughts saying "hit him, hit him, really hard, that is not enough" he then regained control and ran away. He reported to Dr Nielsen walking back to Walsgrave Hospital where he saw a patient there who he thought was his mother. He then reports that he took a 'bus back to Leicester where he passed his parents' house and slashed all the tyres on his step-father's car.' He visited his friends in turn but nobody would put him up. At that point he felt very low "I wanted all of this to end" so he took 10 co-proximal tablets. He then took a 'bus back to Coventry whereafter he went to Walsgrave Hospital.'

6.9 Dr Nielsen noted James Stemp to be agitated on discussing his parents and the events of the previous evening. He made good eye contact but was occasionally quite hostile. His speech was recorded as "lots of it! Normal modulation and form but thoughts wandering, rambling". Mood "angry, very anxious". "Mood swings, but generally very agitated, angry, potentially hostile". Dr Nielsen's reaction was of a "very disturbed young man query organic cause, potentially very aggressive". Dr Nielsen made the differential diagnosis of a personality disorder, a psychotic illness, query secondary to head injury, or an organic brain disease. She admitted him for observation.

6.10 Although James Stemp told Dr Nielsen that he had not taken any drugs, Dr Nielsen told the Inquiry that she would not ordinarily accept that at face value and, with hindsight, should have taken a urine sample for a drug screen. That was not in fact done either on the evening of the 19 February or the next day by Dr K Sultan, the ward doctor.

6.11 By the end of her time as Duty Doctor Dr Nielsen noted James Stemp to be much calmer nevertheless she had written up a prescription for Haloperidol 5mg imi prn (intramuscularly, when required), an anti-psychotic drug. Dr Nielsen did not know that the use of Haloperidol in the circumstances was contrary to protocol. The drug record indicates that at 2200 hours on the 20 February 1995 James Stemp was given 5 mg of Haloperidol by injection but no reason was given for this. Dr Nielsen had no further contact with James Stemp.

On the following morning, the 20 February 1995, James Stemp was seen by Dr Sultan who recorded a similar history to Dr Nielsen and, in particular, noted the threatened violence by James Stemp towards his step-father. Dr Sultan did not consider James Stemp to exhibit any signs of significant mental illness.

6.12 After a ward round and multi-disciplinary meeting on the 21 February 1995 held by the Consultant, Dr Whitehouse, the decision was made to discharge James Stemp with a follow-up out-patient's appointment. The notes suggest that the Social Worker working with the multi-disciplinary community mental health team, Malcolm Hunter, was asked to make a social assessment of James Stemp but Mr Hunter does not recall any such request and, in any event, recollects that James Stemp did not wish any assistance. This was not formally recorded in any clinically available notes.

6.13 The nursing notes made by Staff Nurse C Rimmer on the morning of the 22 February 1995 state "James expressed anxieties and uncertainties about fellow patient Kaz who was released from seclusion and asked for PRN medication. He stated he felt like hitting this patient and hinted he would do something soon James written up for PRN Haloperidol 5 mg given orally at 11 a.m." (There is no note in the clinical records to confirm that prescription or to indicate which Clinician prescribed it. That is particularly concerning when Dr Sultan had stopped the drug on 21 February 1995 and the drug was in any event prescribed contrary to the protocol in relation to rapid tranquillisation). This episode of threatened violence was not communicated to Dr Whitehouse and a decision was made to discharge James Stemp on the 23 February 1995. In the event that did not take place because he had no money, no accommodation and no means of Social Services help on that day.

6.14 The evidence to the Inquiry provided a conflict between Dr Whitehouse and the nursing staff as to the reason for keeping James Stemp beyond the 23 February. Dr Whitehouse considered that there must have been a clinical reason beyond the social difficulties, but if there was, nothing was recorded in the notes. Indeed the Inquiry found there to be an absence of any clinical notes between the 23 and the 28 February when James was actually discharged. When he was discharged, the discharge letter recorded the General Practitioner as unknown, showed the key worker to be Dr Whitehouse and named Mr Hunter as the contact point for James Stemp. Neither of those gentlemen were aware of nor were consulted about their roles in this respect.

James Stemp does not appear to have been given a date for an out-patient appointment but, if he was, it was not adequately recorded. No Care Programme Approach Assessment (to which the Inquiry gives detailed consideration below) had been carried out and no documentation completed. No discharge plan was adequately prepared.

6.15 On the 9 March 1995 Malcolm Hunter formally opened a file in relation to James Stemp. Mr Hunter thought that this was in response to a request from Dr Whitehouse following a further overdose by James Stemp but this date cannot be explained by reference to any of the clinical records. Subsequent to his evidence to the Inquiry, Mr Hunter considered that he may inaccurately have recorded the date. Mr Hunter attempted to see James Stemp on two occasions until successful contact was finally made on 24 March 1995. By this time James Stemp had resolved his benefit problems and had made contact with the Homeless section of Leicester City Council for the purposes of obtaining accommodation. Mr Hunter formed the view that James Stemp required some help finding constructive activity however and took him to the Wyvern Centre where he was able to see, for example, a range of outdoor activities in which he could participate. Although James Stemp joined up whilst Mr Hunter was with him he did not thereafter return to the Wyvern Centre and failed to be available for the follow up appointment which Mr Hunter arranged for the 30 March 1995. Whilst Mr Hunter saw him for a last time on 7 April 1995, James Stemp agreed that he needed no further contact with the Social Worker at that time. He was advised that he could contact the Department again if help was required but he did not do so prior to the offence.

6.16 Although the dates are uncertain, up until the beginning of March 1995 James Stemp was registered with a General Practitioner, Dr B Lucas, in Beaumont Leys. On 7 March 1995 he attempted to obtain treatment from a Dr B Modi but did not attend when an appointment was made for him. On the 10 March 1995 James Stemp then went to see Dr H D Vyas, with whom he had not previously been registered, and obtained a prescription for a 10 day supply of diazepam upon the (false) basis that he had been prescribed this by the hospital. Unfortunately there are no records of any checks on this information having been made, the reason for the prescription or the history given.

6.17 On the 13 March 1995 James Stemp attended the Leicester Royal Infirmary with a history of having taken an overdose of diazepam. He was noted still to be a suicidal risk by the House Officer and was reviewed by Mr D Rowell, the Clinical Nurse Specialist to Dr T Friedman, the Consultant in charge of the Deliberate Self-Harm Team. Mr Rowell records that, since his head injury, James Stemp felt he had become vicious, aggressive, depressed and suicidal. Mr Rowell noted the impression "was that he was not suffering from any psychiatric disorder but has personality difficulty and low coping skills". James Stemp was kept in overnight and discharged to Carlton Hayes Day Hospital the following day.

6.18 It would seem that James Stemp did attend on the 15 March 1995 and may even have gone to the ward at Carlton Hayes Hospital on the 13 March also, where he was seen by Dr Sultan but no records exist of this. Indeed beyond Mr Rowell's notes there was nothing to indicate any liaison with the Day Hospital staff, any further assessment having been carried out, or any communication with James Stemp. Dr Whitehouse recalled being told that James Stemp had attended for meals but not for participation in the activities of the Day Hospital and so he was discharged after non-attendance on the 19 April 1995. Unfortunately no record, beyond the fact of discharge, exists of this either.

6.19 After these events James Stemp did not seek any further medical treatment in relation to any potential psychiatric condition prior to the offence of murder.

6.20 Throughout the period with which the Inquiry was concerned Mr and Mrs Stemp were wholly unaware of James Stemp's admissions to hospital as he remained resolutely opposed to anyone making contact with them either for the obtaining of information or for his own benefit. Thus no attempt to verify the story provided by James Stemp was undertaken.

6.21 James Stemp, in his evidence to the Inquiry, candidly admitted that the history he gave in relation to the events of 19 February 1995 was untrue. He had indulged in the smoking of cannabis and believed that his friends may have spiked his drink with acid as a result of which he had "freaked out" in a way that had frightened him. He therefore concocted the story of a fight with his parents as a means of obtaining some help with this experience and a bed for the night. Had it been possible for the ward staff to make contact with Mr and Mrs Stemp it may have been possible to have discovered this. It would certainly have enabled further investigation of what was regarded by James Stemp as a cry for help.

7. The Relationship of Health and Social Services

7.1 As was recorded by the Independent Inquiry into the treatment and care of Richard John Burton, Leicestershire Health Authority serves a resident population of 926,000 and is the purchaser of a range of psychiatric in-patient and out-patient services as well as supporting Community Services. The Leicestershire Mental Health Service NHS Trust, which was created in 1994, is the main provider of psychiatric services and the Inquiry was told that in the year 1994/5 £36 million was allocated to those services. To support and integrate in-patient services, twenty-five community mental health teams had been established, of which thirteen were for adults/general psychiatry, five of those teams operated within the city, including three on the west side.

7.2 During the period covered by this Inquiry the Social Services Department of Leicestershire County Council served a similar population and was organised on a headquarters based, strategic and operational co-ordination model.

7.3 The Health Authority is primarily concerned with the development of local health strategy and the "purchasing" of services from NHS and non-NHS providers for Leicestershire residents. In order to ensure collaboration between Health and Local authorities, a statutory body was established in Leicestershire, in common with every other Health Authority, known as the local Joint Consultative Committee. To help ensure that the strategy for mental health problems was developed in conjunction with other agencies, the Joint Strategy Group (Mental Health) was set up. This group includes representatives of the Health Authority, users of the service and their carers, the voluntary sector, the Leicestershire Probation Service, the Social Services Department of Leicestershire County Council, and the Leicestershire Mental Health Service NHS Trust. The group makes recommendations on strategic developments and the effective implementation of national mental health policy within Leicestershire.

7.4 In 1994 to 1995 there was much change in the provision of mental health services. National policy required there to be a move to the delivery of high quality services within the community. One of the key strategic issues facing Leicestershire was the effective implementation of the Care Programme Approach. This national policy had come into force in 1991 but, in common with many other Health Authorities, it had been slow to be implemented. However in 1994 a major initiative was undertaken to ensure a more effective implementation of the Care Programme Approach (CPA). A steering group, led by the Director of Nursing and Quality for the Trust and including staff from different interested groups, was set up to manage the process of implementing the CPA. For the purposes of achieving CPA implementation a CPA Manager was appointed, Mr John Rospopa, by the Leicestershire Mental Health Service NHS Trust.

8. The Implementation of the Care Programme Approach

8.1 For the purpose of providing mental health services the City of Leicester was divided into two localities, East and West. Whilst the Inquiry was concerned with the City West locality when considering the treatment of James Stemp, it had no reason to believe that this locality was any better or indeed any worse in relation to the implementation of the CPA than any other locality in the County. The responsibility for purchasing the services rested with Stephen Gale, the Locality Commissioning Manager and Lead Manager for Mental Health for Leicestershire Health Authority.

The Locality Manager for City West for the Leicestershire Mental Health Service NHS Trust was (and is) Ruth Sadler who was directly responsible for the line management of the personnel providing the service.

From Social Services Malcolm Hunter, one of the specialist mental health social workers for the relevant City West team, was line managed by

Colin Foster who liaised regularly with Ruth Sadler to ensure co-operation within the multi-disciplinary teams.

8.2 Inevitably there were some difficulties associated with employees from different agencies, with different line managers, working as a team. Malcolm Hunter described himself as being attached to the team rather than being part of it. The extent to which the teams worked well together was undoubtedly due as much to personality as to any effective inter agency policy. The Inquiry had no reason to believe that the City West team was any different in this respect to the rest of the County either.

8.3 Generally speaking, the Community Mental Health Social Work Team would tend to work with those patients assessed as medium to high dependency whereas those considered to be low dependency individuals would be dealt with (if appropriate) by the Social Services Access system.

8.4 The philosophy behind the CPA was to provide appropriate multidiscipline (but predominently health led) consideration to the discharge and continuing needs of all the patients who had been admitted, for however short a time, with Mental Health problems.

8.5 With this in mind a revised CPA policy was agreed between the Health Authority, Social Services and the Leicestershire Mental Health Service NHS Trust and was launched in Leicestershire in February 1995. Thus at the time that James Stemp was admitted to Carlton Hayes Hospital the revised policy had only been running for a matter of two weeks or so. In order to facilitate effective implementation Mr Rospopa was responsible for arranging extensive training in January and February 1995 targeted at multi-disciplinary team members. The deliberate target was the staff who would have to operate the policy rather than the managers. Unfortunately, despite this objective and much hard work on the part of those carrying out the training to some 600 people, the perception of the staff who gave evidence to the Inquiry was that there was little or no training for CPA.

8.6 It was noted that there was a very low attendance of medical staff during the courses and an almost non-existent response from local General Practitioners This tended to be representative of the attitude to CPA as a whole. Essentially, if a Consultant Psychiatrist in charge of the team was positive about the concept, then CPA would be properly implemented, but, if not, then it was highly unlikely that it would be dealt with properly or at all. The Inquiry must record that Dr Whitehouse, the Consultant in charge of James Stemp and also Clinical Director of the City West Mental Health Team, wholly appreciated the aims of CPA and endeavoured to deal with them. He acknowledged that the failure to complete the appropriate assessment of James Stemp and to consider his care on discharge was unacceptable.

8.7 The Inquiry, which had some sympathy with the obvious frustration felt by Mr Rospopa, noted in his evidence the difficulty he had in getting all the

participants in the policy to understand that they must work in collaboration with Social Services and non-statutory agencies and vice versa. He also felt that managers needed to ensure that the policy was implemented and be held accountable for the failure of the policy where necessary. Upon the admission of all participants, the implementation of CPA was, at the time of the offence of James Stemp, patchy.

8.8 Notwithstanding this background, the Inquiry expected that the likely optimum performance for CPA would be immediately after it had been reintroduced. It was all the more unfortunate therefore that no consideration whatsoever would seem to have been given to any of the requirements of the Policy or indeed the need to fill out the short screening form whilst James Stemp remained in De Montfort ward at Carlton Hayes Hospital. In fact the need to screen James Stemp for CPA was completely missed by the admitting nurse and by all the subsequent personnel who had any contact with him. The Inquiry finds however that this was not a deliberate decision to avoid the requirements of CPA but an unfortunate omission.

9. The Substance of Witness Statements to the Inquiry

9.1 All the witnesses were invited to comment on their view or recollection of the matters with which the Inquiry were concerned.

9.2 James Stemp, interviewed at HM Young Offenders Institute Swinfen Hall by two members of the Inquiry Panel, was both helpful and illuminating in relation to his experience. As has already been noted, it was unfortunate that, having embarked upon the story which he concocted for the events of the 19 February 1995, he thereafter felt compelled to perpetuate it since it confused the clinical picture and prevented the health care professionals from considering his distress. James Stemp felt that, with the number of people he had seen, it should have been possible for someone to have become close to him and appreciated "what was going on in his head". He accepted that, even if this had been achieved, he may not have responded favourably to the situation but felt that he was deprived of the opportunity.

The one major regret which James Stemp had was that he believed he had been offered the chance of anger management therapy when attendance at the Day Hospital was put forward which was something he welcomed. When he in fact attended however he was told that he was too young. James Stemp firmly believed that anger management therapy would have been of help to him. The Inquiry has no reason to disbelieve James Stemp when he indicated this was offered to him but, like other references to the Day Hospital, no record whatsoever exists of it.

9.3 Mr and Mrs Stemp were clearly confused and distressed at the events that had taken place. Apart from wishing to understand what had happened to James Stemp during his admissions in the relevant period, they did not feel there was any additional multi-agency assistance which could or should have

been given to James Stemp or the family which would have avoided the unfortunate events.

9.4 The clinicians and nurses who assisted the Inquiry did their best to help and were candid in their evidence. Each expressed considerable surprise that James Stemp should have committed the offence in question and generally made the observations that he presented as a person with personality difficulties and low coping skills who was more of a risk to himself than to others. Only Dr Nielsen ever felt threatened by James Stemp and this only for a short period whilst challenging his history during her lengthy interview with him. Even so, Dr Nielsen described no more than some unease in James Stemp's presence which passed when the admitting nurse returned to the room.

9.5 The Social Work Staff who were interviewed felt that, in the City West locality, generally speaking co-operation with the Health Services worked well. They also considered the implementation of CPA to be patchy at the relevant time, although were at pains to point out that significant improvements had been made since the period under investigation. Mr Hunter did feel, and the Inquiry would concur, that it would be appropriate when as part of the CPA process a Social Work assessment of an in-patient was required by the clinical team that this be formalised and a document to acknowledge the request for such assessment be generated. It was clear however that, even if more documentation relating to Social Services involvement had been generated, which would have been preferable, James Stemp would not have fulfilled the criteria for any significant social work involvement. Unfortunately James Stemp fell into the category of a young, jobless, homeless male, of whom there are many. Neither the policy nor resources of the Department of Social Services and, in particular, the Community Mental Health Team within which they operated, extended to coping with these social difficulties.

9.6 The General Practitioner who prescribed diazepam to James Stemp, Dr Vyas made clear his difficulties, as a single-handed practitioner, in obtaining the resources to deal with what he perceived to be new policy. He was wholly unaware of the CPA and did not appreciate the presence or organisation of the Community Mental Health Teams.

9.7 Those clinicians, nurses and managers involved with the implementation of CPA acknowledged a need to improve compliance with this policy. It was also acknowledged, generally, that in the case of James Stemp the record keeping, particularly generated from Carlton Hayes Hospital, was inadequate.

10. Consideration of the Matters required to be investigated by the Inquiry under its Terms of Reference in the light of the Evidence received (The headings are taken from the terms of reference see Appendix A)

10.1 The quality and scope of his health, social care and risk assessments

10.1.1 James Stemp received appropriate care and assessment at both Walsgrave Hospital and the Leicester Royal Infirmary.

10.1.2 De Monfort ward at Carlton Hayes Hospital had recently moved locations and suffered from being staffed with new and/or inexperienced staff. The Ward Manager, Mr D Knight, had been in post for a matter of 6 days (although he was familiar with CPA), Mrs B Kramer had been qualified as a Mental Health Nurse for only 6 to 8 months, and Drs Nielsen and Sultan had been in post for 3 weeks. The Ward was oversubscribed with patients. The Inquiry was told that there were more patients than beds on the ward so that some had to be discharged for the weekend to create space.

The Inquiry recognises that all the relevant personnel were doing their best in difficult circumstances.

10.1.3 However, the standard of health care received by James Stemp at Carlton Hayes Hospital fell below that which might reasonably be expected in the following ways:-

a) From 1 February 1995 every person admitted to the psychiatric services should have been screened for CPA. James Stemp was not. No explanation for this failure was offered by any of the witnesses who came before the Inquiry. It was most unfortunate that the procedure had not been followed by the admitting nurse, the assessing doctor or any of the multi-disciplinary team concerned with the care of James Stemp.

b) No risk assessment was carried out at any stage.

c) No screening for drugs was carried out on admission or at any stage thereafter.

d) Despite the history given by James Stemp of threatening his step-father with a knife no attempt to locate a weapon was made on admission. The property check protocol was not adhered to.

e) The level of observation to be carried out on the ward was not documented. It was standard practice to have continual reassessment by the nursing staff of the level of observation and this also was not done nor documented. The fact that James Stemp admitted lying in relation to the recorded events does not negate this.

f) The only care plan which was recorded, was that of the 19 February 1995. The original care plan failed to address significant issues given the presenting history. There was no further care plan produced in the period immediately following admission and the original one was not re-evaluated in the light of the ward meeting on 21 February 1995.

Although there would seem to have been an evaluation of the care plan on the 25 February 1995 no new care plan was drafted. Indeed, notwithstanding the reference in the ward round record, made by Dr Sultan, to Dr Whitehouse seeing James on that day no entry exists of the outcome of that assessment.

g) No discharge plan was completed. James Stemp was discharged to no fixed address without identification of a General Practitioner and no recorded outpatient appointment. Since there was no address, no appointment could be forwarded to him.

h) The multi-disciplinary team meetings were not recorded adequately and no record of the personnel actually present was made.

i) Arrangements for appointment of a primary nurse were not clear.

j) It was unacceptable for James Stemp to be given Haloperidol on the 22 February when it had already been stopped by Dr Sultan and a note of this was entered into the nursing notes as it may 'block accurate assessment'. The use of Haloperidol was contrary to the guidelines on rapid tranquillisation for disturbed behaviour. No clinical signs to warrant its use were recorded in the notes. Although written up originally by Dr Neilsen for use on the night after admission the use of the drug was stopped by Dr Sultan and no signature exists to establish which member of staff subsequently decided to use it again. Whoever prescribed it has not identified themselves in the clinical notes and the dystonic reaction suffered by James Stemp would seem to have been avoidable.

k) There was a complete lack of medical and nursing records from the Day Hospital, which Dr Whitehouse acknowledged to be unacceptable. However the evidence suggests that James Stemp did not take advantage of any help that may have been available to him there. Although he indicated that what he wanted most was anger management therapy, as he had been promised, James Stemp gave evidence that, in the absence of such treatment, he did not feel any positive help would be forthcoming to him at the Day Hospital. Although he felt desperate for someone to understand the emotional turmoil and distress he was feeling, he was not able to communicate it. It is impossible now to determine whether any different approach would have enabled James to speak of his perceived difficulties.

10.4 The extent and standard of Social Services help was appropriate, even if it was carried out in a relatively haphazard manner. It would have been more satisfactory if the referral by Dr Whitehouse to Mr Hunter had been formally documented.

10.5 **The appropriateness of his treatment, care and supervision in respect of his assessed health and social care need and his assessed risk of potential harm to himself and others taking account of any previous psychiatric history, including drug and alcohol abuse and the number and nature of any previous court convictions.**

10.5.1 Most of the observations of the Inquiry are already documented in 10.1.3 above.

10.5.1 Although the Leicester Royal Infirmary notes refer to James Stemp as being an intravenous drug abuser there is no indication that was true. Indeed, although James Stemp admits to having used various drugs during the relevant period, the hospital records suggest that he did not show the type of withdrawal symptoms that would be expected of a significant abuser or indeed any withdrawal symptoms at all. Equally James Stemp had only recorded relatively small scale offending prior to the murder. There is therefore no reason to consider that his treatment or care should have highlighted any particular response to drugs or alcohol.

10.6 **The extent to which James Stemp's care was provided in accordance with statutory obligations, relevant guidance from the Department of Health, including the Care Programme Approach, HC(90)23, LASSL(90)11, Supervision Registers, HSG(94)5 and Discharge Guidance HSG(94)27 and local operational policies.**

10.6.1 Mr Stemp did not receive care in accordance with CPA. It should have been considered even though in this case no different result would necessarily have ensued. In another case this failure may have had very significant consequences.

10.6.2 James Stemp did not fulfil the criteria for placement on the supervision register or the discharge guidance contained in HSG(94)27. The respect in which his care was lacking was in relation to there being no co-ordinated discharge plan which was effectively communicated to the multi-disciplinary agencies or to a relevant General Practitioner.

10.7 **The extent to which his prescribed plans were effectively drawn up, delivered and complied with by James Stemp.**

10.7.1 The care plans were not properly drawn up on De Monfort Ward at Carlton Hayes Hospital as noted above. Written records fail to indicate the extent to which James Stemp may have actually received worthwhile communication with the staff whilst on the ward.

10.7.2 As stated above he had no effective co-ordinated discharge plan. There should have been proper communication with a General Practitioner, an appropriate key worker identified and a definite provision for out patient follow up made.

Even if that had been done though it is debatable whether James Stemp would have persisted in attending or would have been perceived to be a risk to others.

10.8 **To consider the appropriateness of the professional and in-service training of those involved in the care of James Stemp, or in the provision of services to him**

10.8.1 Despite the efforts of Mr Rospopa, there was an absence of perceived effective training for CPA. The staff of De Montfort Ward who gave evidence to the Inquiry said that they had not in fact received any training in CPA prior to implementation, although the members doubted whether that was strictly accurate. It is a matter of concern though that the staff who were to be responsible for operating the policy seemed inadequately prepared to do so despite much time, money and effort being spent on training in advance. The Inquiry did not doubt the quality of the training or the commitment of those providing it, only the ability of the training to target those most in need when, as was inevitable, resources did not allow the inclusion of every member of staff concerned with mental health.

10.8.2 Dr Nielsen and Dr Sultan had not been trained effectively (if at all) in the CPA process, risk assessment or ward procedures. Neither knew that the protocol for rapid tranquillisation discouraged the use of Haloperidol or that it was not considered appropriate for use in these circumstances by Dr Whitehouse.

10.8.3 Although Mr Gale pointed out that the Leicestershire Health Authority was a purchaser of services only and not responsible for operational management or supervising the training provided by the Trust, the Inquiry formed the view that there remained a responsibility on the purchaser and the CPA Steering Group to ensure that the services being bought, including training, were adequately carried out. If the body paying for the service did not, it is difficult to see who would.

10.8.4 There was an absence of one person directly responsible for CPA in the practical setting. The Inquiry found that surprising. In addition it would be helpful for every ward to have its own designated copy of the CPA guidelines appropriately marked and easily located. If there was supposed to be a copy readily available the Inquiry found no evidence that the staff of De Montfort Ward, at the relevant time, knew of it or could locate it.

10.9 **To examine the adequacy of the collaboration and communication between the agencies involved in the care of Mr Stemp or in the provision of services to him and the statutory agencies and Mr Stemp's family.**

10.9.1 This left something to be desired. In particular the Inquiry noted the following:

a) The opening of the social services file on 9 March 1995 when there was already a reference to assessment in the clinical notes on 21 February 1995.

b) There was no recorded communication from the social worker back to the clinician who referred James Stemp save for the provision of a copy of the closing summary.

c) There was no communication to Mr Hunter that James Stemp had not attended two outpatient appointments and had been lost to the system.

d) There was no adequate record of the team meetings as already observed.

e) If there are to be multi-disciplinary teams there ought to be common patient records or a sharing of key information. Databases, Computer Systems and Programmes in use for the Mental Health Service NHS Trust and Social Services which were at least compatible, may be a start.

10.9.2 Communication with a General Practitioner was sadly lacking. James Stemp should not have been discharged to "GP unknown." However the Inquiry recognises that a proportion of young people will move around and not remain constant with a GP practice so that inevitably there will be loss of contact. Unfortunately that would seem to be an insoluble problem. The criticism in this case is that, in the circumstances, this was bound to happen since no attempt was made from the start to obtain nor record details on discharge.

10.9.3 The Inquiry also found it of concern that a General Practitioner would prescribe Diazepam to a new patient without any record of a check having been made with the hospital that this was appropriate.

10.9.4 There was no communication with Mr and Mrs Stemp at all by any of the statutory agencies but that was caused by James Stemp's insistence that he did not want them to be contacted. Whilst information from Mr and Mrs Stemp would have been invaluable in appreciating the inaccurate history, it is highly unlikely that it would have led to any alternative treatment being provided. The breaching of confidentiality in relation to a patient over the age of 16 is a vexing and difficult issue in respect of which the Inquiry does not consider there to be an easy answer. However, it is of concern to note that there was no reassessment made of the threat of harm to his parents expressed by James, which, had his threat been real, could have led to very severe consequences. The Inquiry doubts whether absolute confidentiality is an appropriate goal when the welfare and safety of others potentially is at stake.

11. Conclusions

11.1 No diagnosis other than that of personality disorder in relation to James Stemp was made. At no stage during his admission to Carlton Hayes Hospital was an appropriate risk assessment carried out. The Inquiry could find no objective evidence that those involved with his care had considered whether he was telling the truth or not. If they did not believe the history put forward by James Stemp that was not recorded. If they did believe it, it is difficult to understand why the threats to James Stemp's step-father and to a fellow patient were not taken more seriously. Although the clinicians and nursing staff indicated that they could not breach confidentiality and approach Mr and Mrs Stemp there was no recorded consideration of whether the risk posed by James Stemp's recorded threats were sufficient to justify that breach. Whilst the Inquiry appreciates the difficulty of making contact with family members when the patient does not wish it, it is believed that more could have been considered in this respect.

11.2 As is already recorded, the documentation available in relation to Carlton Hayes Hospital and the Day Hospital left much to be desired. There are no ward reports, the nursing notes are sparse, no care plan on discharge existed nor was attempted and no record of re-evaluation of the presenting symptoms during the course of James Stemp's stay is present.

11.3 It was wholly inappropriate that James Stemp should have been discharged to the care of a General Practitioner recorded as "unknown" and, if James Stemp was in fact told to register with a General Practitioner and report back to the ward with details, as the Inquiry was told, that should have been recorded. It was inappropriate to refer to Dr Whitehouse and Mr Hunter as the relevant personnel on the discharge sheet without consulting them. There was not even a record of James Stemp being given or sent an out-patient appointment card. The discharge sheet recorded that the next out-patient appointment was to be fixed at a later date. It is wholly inappropriate, in the view of the Inquiry, that any young person presenting as James Stemp did, with no permanent address nor General Practitioner, should be discharged without a fixed appointment.

11.4 The Inquiry viewed the lack of a proper risk assessment and an appropriate discharge plan as a "lost opportunity".

11.5 It is accepted that, even if properly assessed, James Stemp was likely to have been regarded as of low dependency so that when he did drop out he would not have been actively pursued. Even so, that is not a reason for discharging a young man in circumstances where he almost certainly will drop out.

11.6 At the age of 17, as James Stemp then was, it is not possible to make a firm diagnosis of personality disorder, particularly in the absence of corroborative evidence. Had James Stemp been diagnosed as having a personality disorder based upon a proper assessment, which is speculative, this would have been a

criteria for inclusion in CPA in Leicestershire. However, the clinicians concerned seemed not to appreciate that fact.

11.7 Notwithstanding those observations, it is clear from the evidence that James Stemp did not present as someone who posed a significant risk either to himself or to others. The individuals who gave evidence to the Inquiry were universal in their shock and surprise that he had committed the offence in question. Even if properly assessed therefore and an appropriate care plan prepared, it is unlikely that James Stemp would have been identified as a high risk individual or that any different outcome would have ensued.

12. Recommendations

12.1 The Inquiry did not expect to have to make this recommendation, but once again the Inquiry emphasizes the need to make and keep a full and proper record of every aspect of the multi-disciplinary care provided.

12.2 There should be a risk assessment carried out on or shortly after admission. That risk assessment should be reviewed regularly and appropriately.

12.3 There should be a full assessment for CPA in respect of every patient.

12.4 One identified person should be directly responsible for ensuring that CPA is carried out.

12.5 Within the multi-disciplinary team there should be increased and properly recorded communication. Any request for social work assessment and/or intervention should be recorded formally and clearly communicated, in writing, to the social worker. Consideration should be given to the use of one set of multi-disciplinary records.

12.6 Patients should not be discharged without an adequately prepared discharge plan or any outpatient or follow up appointments required after discharge being made and the details communicated to the patient. Discharge should be to an identified General Practitioner with whom the patient has already registered.

APPENDIX A

LEICESTERSHIRE HEALTH AUTHORITY

The Independent Inquiry pursuant to HSG (94) 27 into the Care and Treatment of James Stemp 1995

Remit for Inquiry

1. To examine all the circumstances surrounding the treatment and care of Mr James Stemp by the mental health services, including primary care, up until the murder of Mr John Dawson in October 1995, in particular:

   a. the quality and scope of his health, social care and risk assessments,

   b. the appropriateness of his treatment, care and supervision in respect of:

      i. his assessed health and social care needs and
      ii. his assessed risk of potential harm to himself and others

      Taking account of any previous psychiatric history, including drug and alcohol abuse and the number and nature of any previous court convictions,

   c. the extent to which Mr Stemp's care was provided in accordance with statutory obligations, relevant guidance from the Department of Health, including the Care Programme Approach HC(90)23, LASSL(90)11, Supervision Registers HSG(94)5 and Discharge Guidance HSG(94)27 and local operational policies,

   d. the extent to which his prescribed care plans were

      i. effectively drawn up

      ii. delivered and

      iii. complied with by Mr Stemp

2. To consider the appropriateness of the professional and in-service training of those involved in the care of Mr Stemp, or in the provision of services to him.

3. To examine the adequacy of the collaboration and communication between:

   a. the agencies involved in the care of Mr Stemp or in the provision of services to him and

   b. the statutory agencies and Mr Stemp's family

4. To prepare a report and make recommendations to Leicestershire Health Authority.

5. To consider such other matters as the public interest may require.

APPENDIX B

PROCEDURE ADOPTED BY INDEPENDENT INQUIRY

1. Every witness of fact will receive a letter in advance of appearing to give evidence informing them:

   a. of the terms of reference and the procedure adopted by the Inquiry; and
   b. of the areas and matters to be covered with them; and
   c. requesting them to provide written statements to form the basis of their evidence to the Inquiry; and
   d. that when they give oral evidence they may raise any matter they wish, and which they feel might be relevant to the Inquiry; and
   e. that they may bring with them a friend or relative, member of a trade union, lawyer or member of a defence organisation or anyone else they wish to accompany them, with the exception of another Inquiry witness; and
   f. that it is the witness who will be asked questions and who will be expected to answer; and
   g. that their evidence will be recorded and a copy sent to them afterwards for them to sign.

2. Witnesses of fact will be asked to affirm that their evidence is true

3. Any points of potential criticism will be put to a witness of fact, either orally when they first give evidence, or in writing at a later time, and they will be given a full opportunity to respond.

4. Any other interested parties who feel that they may have something useful to contribute to the Inquiry may make written submissions for the Inquiry's consideration.

5. All sittings of the Inquiry will be held in private.

6. The findings of the Inquiry and any recommendations will be made public.

7. The evidence which is submitted to the Inquiry either orally or in writing will not be made public by the Inquiry, save as is disclosed within the body of the Inquiry's final report.

8. Findings of fact will be made on the basis of the evidence received by the Inquiry. Comments which appear within the narrative of the Report and any recommendations will be based on those findings.

APPENDIX C

LETTER TO WITNESSES

Independent Inquiry pursuant to Health Service Guidelines (94) 27 into the Care and Treatment of James Stemp

Chairman of the Inquiry
Miss J Adams

Committee Secretariat
Leicestershire Health HQ
Gwendolen Road
Leicester LE5 4QF
Tel: 0116 258 8610

PERSONAL AND IN STRICT CONFIDENCE

Name
Address

Dear

I am writing to invite you to meet with the Independent Inquiry which has been set up to look into the care and treatment of James Stemp by the mental health services, including primary care, until the murder of Mr J Dawson in October 1995. A copy of the Inquiry's Terms of Reference is enclosed and a copy of the Procedure adopted by the Inquiry for your information.

Although the Inquiry is not a legal inquiry, it is to be chaired by me, Jayne Adams, Barrister. The membership consists of Jim McIntegart, a Director of Nursing Services, Shawn Mitchell, Consultant Psychiatrist, and Philip Douglas, a Social Services Operations Manager. The Inquiry will sit in private.

From the initial examination of all the records relating to James Stemp, the Inquiry Panel considers that you may have relevant evidence to give to the Inquiry. The Inquiry Panel would therefore like to meet you on in Conference Room 2 at Leicestershire Health Headquarters, Gwendolen Road, Leicester. A map showing the location is enclosed. Arrangements have been made for you to meet with the Inquiry Panel at on that date. It is anticipated that the meeting will last 45 - 60 minutes. While every effort will be made to adhere to this timetable, circumstances on the day may make it necessary to keep you waiting beyond your allotted time before you are able to meet with the Panel. When you arrive at the

Reception Desk please register with the Receptionist and you will be escorted to a room where you will be asked to wait until the time of your appointment.

You may, if you wish, be accompanied when you meet the Inquiry Panel. This may be by a friend, who may be a representative from your Union or Defence Organisation, a lawyer, or by some other representative with the exception of another Inquiry witness. However, it is to you that questions will be directed and from whom replies will be sought. Your oral evidence will be recorded and a copy will be sent to you afterwards, which you will be asked to sign and return.. It would be helpful if you could confirm that you will attending and whether or not you will be accompanied.

In order to shorten the time on oral evidence, and to help clarify issues before the Panel meeting, we would ask you to provide a written statement setting out and providing a commentary upon your involvement with James Stemp. You will, however, have full opportunity at the Panel meeting to raise any matter you wish, and which you feel might be relevant to the Inquiry. We would be grateful if your statement could define the reasons for your contact with James Stemp, and, in particular, describe your involvement in his treatment and care. I would be grateful if your written statement could reach me by Friday, 15 November, 1996. A prepaid envelope is enclosed for you to use. Alternatively if you have already given a statement to the Police it would be in order for this to be used as your statement but before the Police would release it they would require a written signed statement from you giving them authorisation to release the police statement to the Inquiry Panel. This signed authorisation should be sent to me in the prepaid envelope enclosed.

Copies of the medical records will be available at the Panel meeting should you wish to consult them to refresh your memory or a copy could be made available to you in advance by contacting the above office.

Reasonable travelling expenses incurred in attending the Inquiry will be paid at NHS rates by the Health Authority.

It is intended that a press release will be issued in advance of the meeting of the Panel stating that Leicestershire Health Authority will be holding an independent inquiry.

We would like to thank you for your co-operation and assistance.

Yours sincerely

Jayne Adams
Chairman of the Inquiry

APPENDIX D

LIST OF WITNESSES CALLED

Name	Position
Barraclough, Mr R	Prison Officer
Birtwisle, Mr T	Social Services Manager
Dumughn, Dr C	Duty Psychiatrist
Foster, Mr C	Social Services Manager
Gale, Mr S E	Locality Commissioning Manager & Lead for Mental Health Contract
Hunter, Mr M	Social Worker
Johnson, Miss S	Probation Officer
Kilner, Mr P	Deputy Ward Manager
Knight, Mr D	Ward Manager, Beaumont Ward
Kramer, Mrs B	Community Psychiatric Nurse
Nielsen, Dr F	SHO in Psychiatry
Rimmer, Mr C	Staff Nurse
Rospopa, Mr J	CPA Manager
Rowell, Mr D	Clinical Nurse Specialist
Sadler, Miss R	Locality Manager for City West Locality
Shapero, Dr J S	Consultant Forensic Psychiatrist
Stemp, Mrs J A	Mother
Stemp, Mr J D	Stepfather
Stemp, Mr J R	
Stripp, Mr I	Detective Superintendent

Sultan, Dr K	Registrar in Psychiatry
Vyas, Dr H D	General Practitioner
Watts, Mr T	Social Services Manager
Whitehouse, Dr A	Consultant Psychiatrist

APPENDIX E

References

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Dolan B & Coid J, Psychopathic and Antisocial Personality Disorders - Treatment and Research Issues. Gaskell 1994.

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